STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155165	A. BUILDING 00 B. WING	07/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW VILLAGE	586 EASTERN BOULEVARD CLARKSVILLE, IN47129

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F0000	This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00090791 completed on 5/24/11. Complaint IN00090791 - Corrected. Unrelated deficiency cited. Survey dates: 7/7 and 7/8/11 Facility number: 000082 Provider number: 155165 AIM number: 100289640 Survey team: Jennie Bartelt, RN Census bed type: SNF/NF: 116 Total: 116 Census payor type: Medicare: 21 Medicaid: 78 Other: 17 Total: 116 Sample: 4 This deficiency reflects state findings cited in accordance with 410 IAC 16.2. Quality review completed on July 13,	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	2011 by Bev Faulkner, RN			
F0329 SS=G	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to monitor to ensure the use of Dilantin for seizure control was indicated. The deficient practice affected 1 of 1 resident reviewed related to Dilantin administration in a sample of 3. (Resident F) Resident F's Dilantin level	F0329	The creation and submission of this Plan of Correction does not constiture an admission by this provider of any conclusion set forth in statement of deficiencies, or of any viloation of regulation.The provider respectfully requests the 2567 Plan of Correction be considered	07/26/2011

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	was above normal range, the medication continued to be administered, the blood level was not monitored again, and the resident was transferred to the emergency room with diagnoses including, but not limited to, Dilantin toxicity. Findings include: The clinical record for Resident F was reviewed on 7/7/11 at 3:00 p.m. The record indicated Resident F had diagnoses including, but not limited to, seizure disorder. Physician's orders for May 2011 included, but were not limited to, an order originally received 10/16/10, for Dilantin 50 mg chew, take 8 tablets (400 mg) by mouth once daily related to seizures, and an order, originally received 9/29/10, for a Dilantin level every three months scheduled December, March, June, and September. A lab report for 3/25/11 indicated the resident's Dilantin level was 17.7 micrograms/milliliter with a normal range of 10 to 20 micrograms/milliliter. Nurse's Notes for 5/16/11 at 6:10 a.m., indicated, "Res. [resident] seizuring while [arrow pointing up] in W/C. Extremities rigid, eyes rolled up in forehead. Full		the Letter of Credible Allegation and requests a post survey review on or after 7/26/2011.It is the practice of this facility to ensure that residents drug regiman is monitored and free from unnecessary drugs.What corrective action will be accomplished for those residents found to have been affected by the deficient practice?1. Regarding R-F, the attending physician was contacted and was seen as per the 2567. The attending physician discontinued the dilantin and ordered Keppra. The attending physician wrote a progress note and stated "Above plan has been discussed with staff, especially management of Dilantin Toxicity,since 7/2/11. "All levels have been called into me" 2. The consultant pharmacist completed a review of all resident medications for unnecessary drugs, any recommendations will be forwarded to the attending physician. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?An audit was completed of all residents receiving dliantin to ensure routine lab orders for monitoring are completed timely. Any issues identified will be reported to the physician.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does	

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	body tremor." A physician's order, received from the nurse practitioner, and dated 5/16/11 at 6:15 a.m., indicated, "Ativan 1 mg IM [intramuscular injection] now. Repeat in 10 min prn [as needed]. CBC [complete blood count], CMP [complete metabolic profile], UA [urinalysis], Tegretol, Dilantin [blood levels]." A physician's order, received from the nurse practitioner, dated 5/16/11 at 6:15 a.m., indicated, "Clarification: Ativan 1 mg IM [intramuscular injection] now R/T [related to] sz's [seizures]. May repeat dose X 1 in 10 min [minutes] if not effective." A lab report, dated 5/16/11 at 8:22 a.m., indicated, "Phenytoin [Dilantin] 24.1 C [small number 2] with normal range of 10 to 20 micrograms per milliliter. A footnote for the small number 2 indicated, "Critical value(s) called to, repeated, and verified by [name]. A handwritten notation on the report indicated, "Hold Dilantin. Call out to Dr. [name of Resident F's attending physician] 5/16/11 9:45 a.m. Awaiting return call." Initials followed the notation. Another notation on the report indicated, "Hold Dilantin in AM. Re [checkmark] Dilantin on Wed."		not recur?3. Licensed staff were re-inserviced by the Staff Development Coordinator on 7/26/2011 regarding lab values, unnecessary drugs, physician notification, and change in condition/hot charting processeswhich included pre-post testing.The pharmacy consultant will conduct a monthly audit of medications. Recommendations for unnecessary drugs will be provided to the facility. The DNS will responsible for ensuring appropriate action is taken.Medication indication for use and necessary labs to monitor will be communicated to the attending physician.Those residents requiring continued assessment for change of condition will be placed on "hot charting" for up to but not limited 72 hours.Any resident with abnormal labs values will be reported to the attending physician.How the corrective actions will be monitored to ensure the deficient practice will no recur, what quality assurance program will be put into place?4. The facility will complete the Labs/Unnecessary drugs CQI, weekly x 8 weeks and monthly x 6 months. The results of the audit will be reviewed with the CQI team monthly. The CQI team will determine the need for continued monitoring. The DNS /or designee will be responsbile for coordinating the audits.	

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	The attending physician's order, dated 5/16/11 at 9:00 a.m., indicated, "Hold Dilantin. Redraw Dilantin level on 5/18/11." The Care Plan Update on the Physician Telephone Order indicated, "Goal: Lab WNL [within normal limits]." The attending physician's order, dated 5/16/11 at 12:00 noon, indicated, "Hold Dilantin in AM 5/17/11 & 5/18/11. Re [check mark] Dilantin level 5/18/11." The Care Plan Update on the Physician Telephone Order indicated, "Goal: Lab WNL [within normal limits]." A lab report, dated 5/18/11, indicated a Dilantin level of 19.5 with a normal range of 10 to 20 micrograms per milliliter. A handwritten notation on the lab report indicated, "Faxed to Dr. [name of attending physician] 5/20/11 [symbol for no] orders." The notation was unsigned. Nurse's Notes for 5/16/11 through 5/23/11 at 6:30 a.m., indicated no seizure activity was indicated during this time. Nurse's Notes on 5/23/11 at 6:30 a.m., indicated, "Seizure activity noted. Rigid, screaming between spasms. Eyes rolled into head." A physician's order, received from the nurse practitioner, dated 5/23/11 at 6:25			

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a.m., indicated, "Ativan 1 mg IM now; STAT Dilantin level."

A lab report, dated 5/23/11, indicated, "Phenytoin 23.5 C [small number 1]" with normal range of 10 to 20 micrograms per milliliter. A footnote for the small number 1 indicated, "Critical value(s) called to, repeated, and verified by [name]. Handwritten notations on the report indicated, "Dr. [name], neuro consult, Hold Dilantin in AM X 2 d [days] Dilantin [level] in AM Wed Dilantin 50 mg tabs - 400 mg once day. Tegretol [anti-seizure medication] 200 mg ii [two] tabs TID [three times daily] for seizures, Keppra 500 mg BID [twice daily] 12 N [noon] - nurse will tell [name of attending physician] as soon as he comes in." Initials were indicated after the last notation on the page.

The attending physician's order, dated 5/23/11 at 1:00 p.m., indicated, "Neuro consult [symbol for with] [name of neurologist]. Hold Dilantin in AM X 2 days. Dilantin level on Wed morning Keppra 500 mg P.O. [by mouth] BID R/T [related to] seizures."

A lab report, dated 5/25/11 indicated, "Dilantin (Phenytoin) 22.6 H [high]" with a normal range of 10 to 20 micrograms/milliliter. A handwritten

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	notation with a circled #1 on the lab report indicated, "MD notified. [symbol for no] N. O. [new orders]." The notation was followed by initials and the date 5/25/11. Another handwritten notation with a circled #2 indicated, "5-23 held Mon. Dilantin until Wed." The notation was unsigned. Another notation was circled with an arrow pointing to the #2 notation, and indicated, "On Dilantin 400 mg once daily. Other notations indicated, "Called nurse at office & re-faxed 5-27-11," " Last lab 5-23-11 Dilantin 23.5," and "Currently on Keppra 500 mg Bid." Another notation with a circled #3 indicated, "5-30-11 Called again & faxed," and was signed with a nurse's first initial and last name. A stamped mark indicating "FAXED" included a handwritten date of 5/27/11. Documentation on Nurse's Notes, Physician's Progress Notes, and Physician's Orders failed to indicate a response or further follow-up with the attending physician related to the Dilantin level above normal, including possible changes in medication dosing or on-going monitoring of Dilantin level. The Medication Administration Records for May, June, and July (through 7/3/11) 2011 indicated the resident's Dilantin was administered at 400 mg daily except for			

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	5/17, 5/18, 5/24, and 5/25/11. Physician's orders for June 2011 indicated the month names on the order for "Dilantin every 3 months December, March, June, September" had been crossed through, and handwritten in was "Aug, Nov, Feb, May." A Short Term Patient Referral Form indicated the resident was transferred for neurological consultation on 6/20/11. "Reason for Transfer" indicated, "Please review attached meds [medications] & labs for any recommendations." Paperwork sent with the resident included the June 2011 Medication Administration Record and the lab reports for Dilantin including the handwritten notations, dated 5/23 and 5/25/11, and urinalysis, dated 6/15/11. A "Neurological Consultation," dated 6/20/11, indicated, "[Resident F]...was seen in our office on 6-20-11 for neurological evaluation through the courtesy of [name of attending physician] who is concerned about the patient's on going and progressive deterioration in memory and cognitive dysfunction. Neurological examination: Awake but unable to communicate verbally. She is combative when an attempt to touch her. We tried placing electrode on her scalp			

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	but were unsuccessful. The patient would move her upper and lower extremity spontaneously and no focal weakness noted. Remarks: This patient is on her late spectrum of dementia, Alzheimer type. Recommendations: There is no need for treating her dementing process except to calm her down prn [as needed] with appropriate medication for her age. Invasive neuroprocedure is not indicated. Continue with all her anticonvulsant medication." Nurse's Notes for June 2011 indicated the resident was treated with antibiotics for "abnormal urine" beginning 6/16/11 with Macrobid [antibiotic] and on 6/29/11 with Tobramycin [antibiotic] injections. The Interdisciplinary Team Note for 6/23/11 indicated the resident's food intake had decreased, she had lost weight, was placed on Megace, and had fortified foods added to the diet. A physician's order, dated 6/27/11, indicated the resident's restorative dining was discontinued, the diet was changed to pureed, and the Care Plan Update on the physician's order indicated the resident now required feeding. The resident's Care Plan, dated 1/10/11, indicated, "Resident has risk for injury related to seizure activity; Has potential for seizure activity." Interventions on the			

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	plan did not indicate a plan for the resident's blood level parameters for Dilantin. Nurse's Notes on 7/3/11 at 6:00 a.m., indicated, "Call placed to [name of attending physician] - res [resident] lethargic and slow to respond. Temp 100.2 cont. [continues] w [with] abt [antibiotic] appetite has been decreased w good fluid intake at most xs [times]. res up in w/c [wheel chair] leaning to rt [right] side has outbursts of yelling then quiets and has moments of fixed stare and won't respond to staff...." Notes indicated the physician returned the call and ordered the resident to be sent to the emergency room for evaluation and treatment. The Physician Emergency Room Documentation, with handwritten date of 7/2/11 [sic] indicated, "Unresponsive. Sent from NH [nursing home] [symbol for secondary to] wouldn't open eyes & [arrow pointing down] resp [responsiveness] this a.m. No C/O [complaints] [illegible word] Hx [history of] F/C [Foley catheter] recently Dx [diagnosis] UTI - on Tobramycin, known seizure disorder - non witnessed." The Emergency Department lab report indicated the resident's Phenytoin Level was 41.5 micrograms/milliliter with a normal range of 10 to 20			

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	micrograms/milliliter, the urinalysis indicated values outside normal ranges, and the blood sugar by Accucheck was 134 at 7:46 a.m. The Emergency Department Discharge Instruction Summary, dated 7/3/11 at 9:48 a.m., indicated the resident's diagnoses were: "Altered mental status, diabetes, Dilantin toxicity, Hx seizure, UTI [urinary tract infection]" Discharge Instructions included, but were not limited to, "Hold DILANTIN - DO NOT GIVE. Recheck Dilantin level Tuesday [7/5/11] AM and advise [name of attending physician] of results. Check urine culture results 3 days. Continue Tobramycin...." A lab report. dated 7/5/11. indicated "Dilantin (Phenytoin) 37.9 H [high]" with normal range of 10 to 20 micrograms/milliliter. The attending physician's order, dated 7/5/11, indicated, "Hold Dilantin for three more days. Repeat Dilantin level on 3rd day." The Care Plan Update on the Physician Telephone Order indicated, "Goal: Lab value will be WNL [within normal limits] next lab draw." A Nursing Progress Note, dated 7/7/11 at 3:45 p.m., indicated, "Called [sic] placed to [name of attending physician] r/t [related to] multi meds for seizure			

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	disorder/dementia. Called [sic] was placed at 9:35 a.m. Message left with office. MD to return call by end of the day or in the am [morning]...." The attending Physician's Progress Notes, dated 7/8/11, indicated, "Patient [symbol for with] recent confusion & [arrow pointing up] agitation. Sent to [name of local hospital] ER [emergency room] on 7/2/11 [sic]. Noted to be Dilantin toxic [symbol for with] level of 41.5. Coumadin [sic] put on hold until level w/in [within] therapeutic level. Dilantin level 7/5/11 was 37. Currently still on hold....A/P [assessment/plan] Seizure Dis [disorder] [symbol for with] Dilantin toxicity Hold & D/C Coumadin [sic]. [arrow pointing up] Keppra. UTI. Completed course of abx [antibiotic]...Above plan has been d/w [discussed with] staff, especially management of Dilantin toxicity since 7/2/11 [sic]. All levels have been called to me." During interview on 7/7/11 at 4:30 p.m., in regard to the lab report of 5/25/11 with the notations about contacting the physician's office, the Director of Nursing indicated a nurse could contact the facility's Medical Director if the attending physician was not responding to contacts.			

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	During interview on 7/7/11 at 5:10 p.m., the Director of Nursing indicated Resident F's Dilantin level had been maintained on the high side to manage her seizures. She also indicated she could not locate any progress notes to indicate the resident's physician had visited the resident and commented on the Dilantin levels outside the therapeutic range until the note of 7/8/11. During interview on 7/8/11 at 10:30 a.m., the Director of Nursing indicated the resident's attending physician would be in to see her today. During interview on 7/8/11 at 12:15 p.m., the Director of Nursing indicated the physician had visited the resident and would be taking the resident off Dilantin so managing the Dilantin levels would not be necessary. The Director of Nursing indicated the resident was doing well now and eating 100%. During interview on 7/8/11 at 1:30 p.m., during the Exit Conference, Unit Manager #1 indicated she had spoken with the nurse who wrote "MD notified. No new orders" on the lab report for 5/25/11. The Unit Manager indicated the nurse told her she had spoken with the physician about the lab. Review of the Geriatric Dosage			

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	Handbook, 12th edition, on pages 1229 through 1235, indicated information including, but not limited to, "Concentration-related effects: Nystagmus, blurred vision, diplopia, ataxia, slurred speech, dizziness, drowsiness, lethargy, coma, rash, fever, nausea, vomiting, gum tenderness, confusion, mood changes, folic acid depletion, osteomalacia, hyperglycemia....Reference range: Therapeutic 10 - 20 mcg/mL [micrograms per milliliter]....Toxicity is measured clinically, and some patients require levels outside the suggested therapeutic range; Toxic: 30 - 50 mcg/mL. Lethal: > [greater than] 100 mcg/mL." 3.1-48(a)(3) 3.1-48(a)(4)			